Theodore Burnett, DDS
8540 S. Sepulveda Bl. Suite 918
Los Angeles, Ca 90045
310-670-0379

OFFICE POLICIES

APPOINTMENTS: When you schedule an appointment at our office, time is set aside specifically for you and your treatment. It is very important that you keep your appointment, or if needed, reschedule it as soon as possible. We **require at least 48 working hours** notice if you must reschedule your treatment. **Missed appointments and those cancelled with less than two days' notice will be subject to a $50.00 charge.**

FOR THOSE PATIENTS WITH INSURANCE: I hereby authorize payment of dental benefits directly to the above named dental entity.

PAYMENT: Payment is expected at the time of service unless prior financial arrangements have been made. If you have dental insurance, our staff will give you an estimate of your insurance benefits and your co-payment, which is **due at the time of service**. ***This is an estimate only***. Residual balances may occur once all insurance payments are received. This can happen even if you are covered by two dental plans. Verification of your insurance benefits never guarantees payment and whatever charges occur are ultimately *your responsibility*. Many variables exist from carrier to carrier (i.e., deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions).

I acknowledge that ALL charges incurred in this office are my responsibility. Should my insurance for any reason fail to pay all charges billed, I agree to pay for services upon notification from this office. I understand that if my account remains unpaid by me for 30 days, it may be referred to a third party for collection and that I further agree to be responsible and pay for all costs incurred.

For your convenience, we accept VISA, MasterCard, Discover and American Express, as well as personal checks. There will be a $25.00 fee for returned checks. We also offer third party financing through Care Credit (revolving credit line with no interest for 6 months).

CONSENT FOR TREATMENT: By signing below, you hereby give this office permission to perform dental treatment for you and your dependent as is necessary and /or desirable and to administer drugs and/or anesthesia as deemed advisable by Dr. Burnett and/or our associates.

I give you and your staff permission to telephone me on my home, cell and work numbers to discuss matters relating to my treatment and/or account.

I have read the above conditions of treatment and payment and agree to their content.

_____ DATE_____ Relationship to Patient_____
Signature of patient, parent/guardian if a minor

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